MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0134-01-SS
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. B, MD

October 8, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurosurgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Medical Director

CLINICAL HISTORY
This is a gentleman who is now ___. Back in ___ he was working as a welder and, for reasons that are not entirely clear, he lost his balance while welding. He fell upwards of 30 feet, struck his head, had a closed head injury and sustained some cranial nerve injury as well. He was subsequently found to have a herniated disc at C5 and has been treated with multiple modalities, all to no avail. He has recently had an EMG which shows an active C6 radiculopathy. His physical exam shows a diminished brachioradialis reflex on the left as well as decreased range of motion and reproduction of his pain with movements.

REQUESTED SERVICE(S)
Anterior cervical discectomy/fusion at C5/6, bone graft.

DECISION
Approved. It is appropriate to proceed on with this surgical procedure.

RATIONALE/BASIS FOR DECISION
This gentleman is exhibiting both neurologic abnormalities, specifically the abnormal reflex that is confirmed by EMG findings and that is also confirmed by imaging findings. He has been through conservative management. He has not made any substantial progress. His symptoms at this point date directly back to the fall in ___. There do not appear to be any options for this gentleman, aside from an anterior cervical discectomy and fusion.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 8th day of October, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: